MARYLAND HEALTH BENEFIT EXCHANGE

Brand Recommendations

May 18, 2012

Branding Objectives

The Maryland Health Benefit Exchange completed an analytic study in the fall of 2011 to identify, segment and prioritize audiences in Maryland for the advertising and public relations campaign.

The following objectives were established for development and refinement of a brand:

- Establish the Exchange's **role and brand value**

- Embrace the role of **"educator"** rather than that of "enforcer"

- Recognize that the exchange will be **completely new** for consumers, requiring **simplification** in brand positioning and communications

- Brand positioning must be **relevant** to all audience segments

- Promotion of the brand must **leverage** the power and brand equity of Exchange partners

- The brand for the Exchange must be a destination for choosing from qualified health plans – emphasizing the **"no wrong door"** policy and open to all

Brand Process and Deliverables

Development Process

o **Brand analysis** across health benefit exchanges in the U.S., based on current practices and planned approaches; review of federal research available for development of FFE

o **One-on-one conversations** with selected health benefit exchange communications directors

o **Online survey** to gather reactions among Maryland adults to a short list of names, in order to identify which name best describes and encourages participation in the consumer portal

Brand Deliverables

o **Recommendation on a short list of brand names and brand rollout strategy**

o **Development of brand name** and logo

o **Development of brand standards**, including use of logo, type styles, color palette and visual style

o **Development of brand templates**, including letterhead/cards/office stationery and PowerPoint template

Research: Quantitative and Qualitative Sources

Study	Audience	Sponsor	Date
Market Analysis and Environment Scan	Maryland and U.S.	MHBE (KRC/ Weber Shandwick)	November 2011
National Focus Groups	Medicaid and Medicare (Cleveland, Dallas, Miami, Houston, New York, Phoenix, Philadelphia)	CMS	January-March 2012
Focus Groups	Medicaid (138% FPL)	Robert Wood Johnson Foundation (Lake Research)	January 2012
Telephone Survey	Medicaid (138% FPL) in MD, AL and MI	Robert Wood Johnson Foundation (Lake Research)	March 2012
Interviews w/ Communications Directors	CA, CO, NY, OR, UT, WV	MHBE (Weber Shandwick)	April 2012
Online Survey	Maryland (up to 400% FPL)	MHBE (HCM Research)	April 2012
Brand Landscape Analysis	Nationwide	MHBE (Weber Shandwick)	April 2012
Search Engine Testing	Online usability testing	Weber Shandwick	May 2012

Executive Summary on Branding

What we learned:	How we learned:
• The terms "exchange" and "connector" test poorly with consumers. Use of the term "marketplace" is preferred.	• Review of branding status of 15 states that have established exchanges
• Use of terms such as "health plans" is better than "healthcare" or "health."	• Interviews with communication leads for exchanges in California, Colorado, New York, Oregon, Utah, West Virginia
• Stand-alone use of terms such as "insurance" or "coverage" imply all types of insurance, not just health coverage.	• MHBE-sponsored research conducted among 250 Marylanders by HCM Research to identify preferred brand names for the Exchange
• "Health Plans Maryland" brand rates highest, although low-income population rates "Maryland Health Connection" highest.	• Review of results of focus groups among low-income Maryland residents conducted by Lake Research Partners and sponsored by RWJF
• With some important exceptions, associations with government or politics tend to be viewed negatively.	• Interview with CMS officials who discussed results of 50 CMS-sponsored focus groups among income-eligible populations conducted in English and in Spanish, and among small business owners, in locations nationally.
• Use of MD as abbreviation results in chaotic web search results due to overlap with M.D.	
• Appealing messages: Quality healthcare, affordable prices, easy comparison shopping, "I'm in control."	• Search engine results testing various names and abbreviations

Names for Consideration

Name	Supporting Points
Health Plans Maryland ***HealthPlansMaryland.com***	• Top ranked across populations • Second ranked among Medicaid-eligible • Top ranked as a place to get information on health plans • Clearly connotes health plans vs. general health or other types of insurance products
Maryland Health Marketplace ***MarylandHealthMarketplace.com***	• Second ranked across populations • Third ranked in Medicaid-eligible focus groups • Fifth ranked in Medicaid-eligible survey • Among top 3 perceived as private vs. govt., and as a place to get information on health plans
Insure Me Maryland ***InsureMeMaryland.org***	• Fourth ranked across populations • Top ranked as affordable • Among top 3 perceived as easy to use, and secure (however not specific about health coverage)
Maryland Health Connection ***MarylandHealthConnection.com***	• Top ranked among Medicaid-eligible • Ranked sixth across population • Closely mirrors successful MA Health Connector program • Top ranked as secure, and among top 3 perceived as trustworthy
Get Covered Maryland ***GetCoveredMaryland.com***	• Eighth-ranked of 10 names tested, however top-ranked in three key attributes: easy to use, high quality, and trustworthy • Uses active rather than passive voice (however not specific about health coverage)

Next Steps

Stakeholder Presentations:

    o Exchange Implementation Advisory Committee: May 31st

    o GOHR Communications Advisory Committee: June 6

Board Decision: June 12th

Launch URL Microsite

Creative Development: June 18th

MARYLAND HEALTH BENEFIT EXCHANGE

Service Center Functionality Options

May 18, 2012

Support Philosophy

Dedicated Seamless Support

The Exchange will strive to achieve excellence by providing **customer centric** support that extends across all Exchange services seamlessly. It will provide a **Consolidated Services Center (CSC)** where the consumer experience is consistent and continuous regardless of the area of service. This model of service is crucial for the adoption and popular acceptance of the Exchange services as well its subsistence for years to come.

Support Strategy – Consolidated Service Center (CSC) Model

CENTRIC MODEL
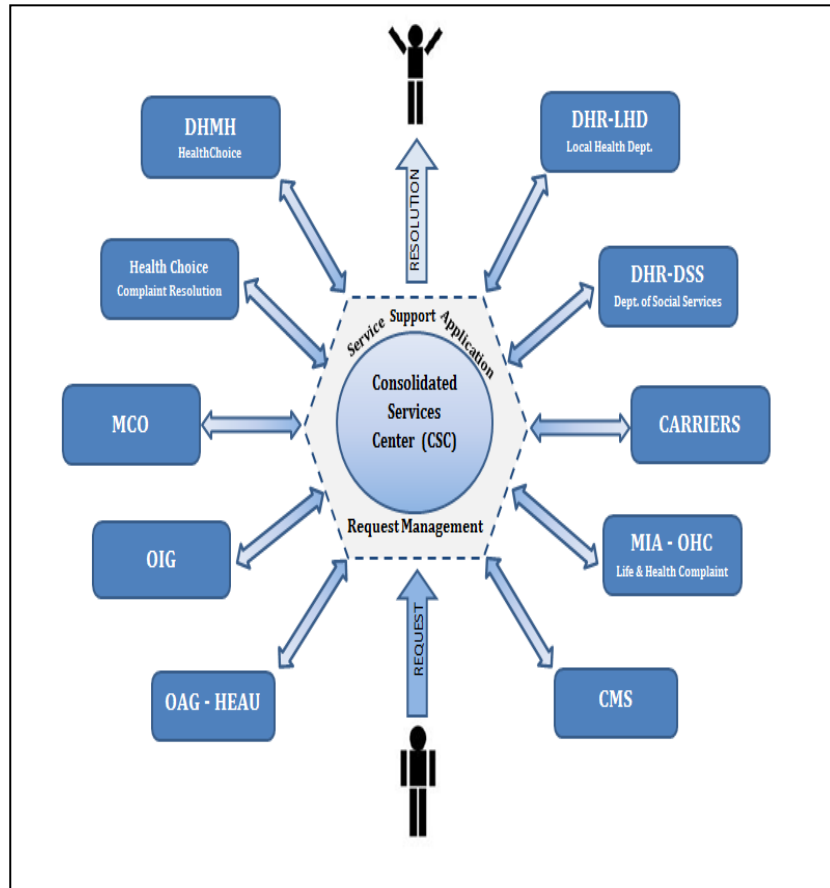
RELAY MODEL
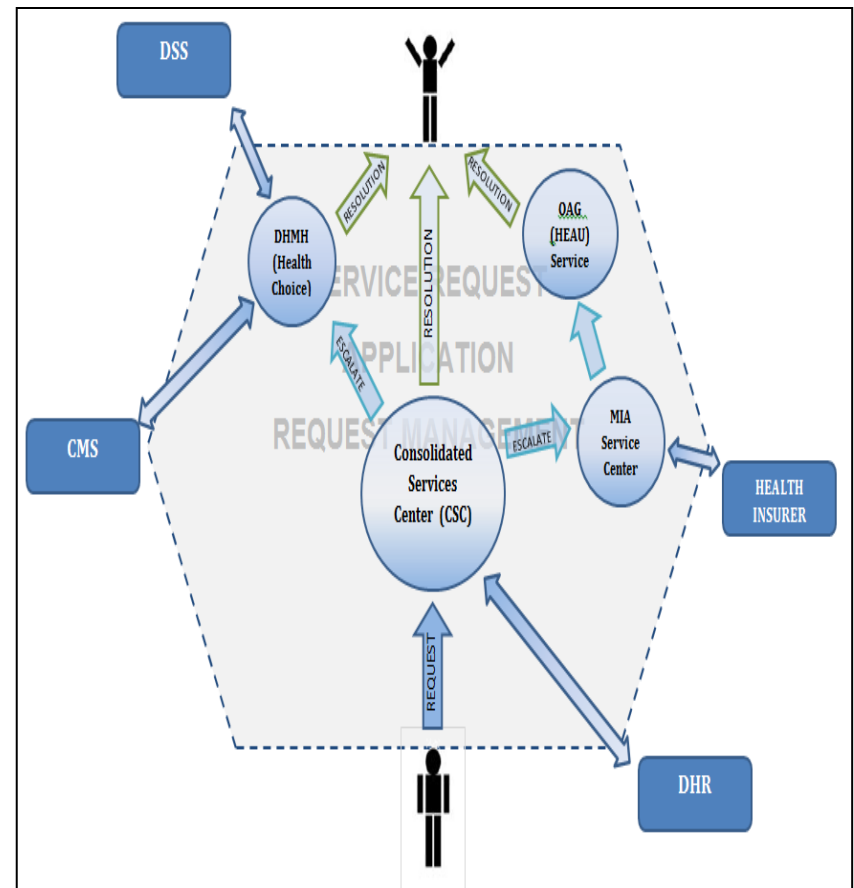
Call-Center Evaluation

The Exchange hired Health Management Consultants to conduct a study on the current State of Maryland Call-Center functionality and resource capacity.

- The primary purpose of the study was to provide the Exchange with an understanding of the current environment and to identify any components that could be utilized in the development of an Exchange call-center

- The study also examined the best practices / lessons learned in regards to the development and implementation of a call-center to meet the needs of the Exchange

- The study evaluated the following call-centers:

    - Health Education and Advocacy Unit (HEAU) of the Office of the Attorney General (OAG) for mediation

    - Maryland Insurance Administration (MIA) Life and Health Complaint Unit

    - Department of Health and Mental Hygiene (DHMH) Health Choice Enrollment Unit

    - DHMH Health Choice Complaint Resolution Unit

Preliminary Outcomes of Study:

- The existing call centers serve specific purposes, distinct difference in population and purpose however none can fully assume the needed Exchange functions

- HealthChoice Enrollment Broker most closely aligned

- Existing call centers can support the Exchange

Call-Center Options

Three high-level options for Call-Center Operations were explored:

Option 1	Option 2	Option 3
Enrollment	Enrollment	Enrollment
Access	Access	Access
Complaints	Complaints	Complaints
Direct Operation by the Exchange	Exchange Partnership Model	Contracted Model

Exchange Other State Agencies Contracted Entity
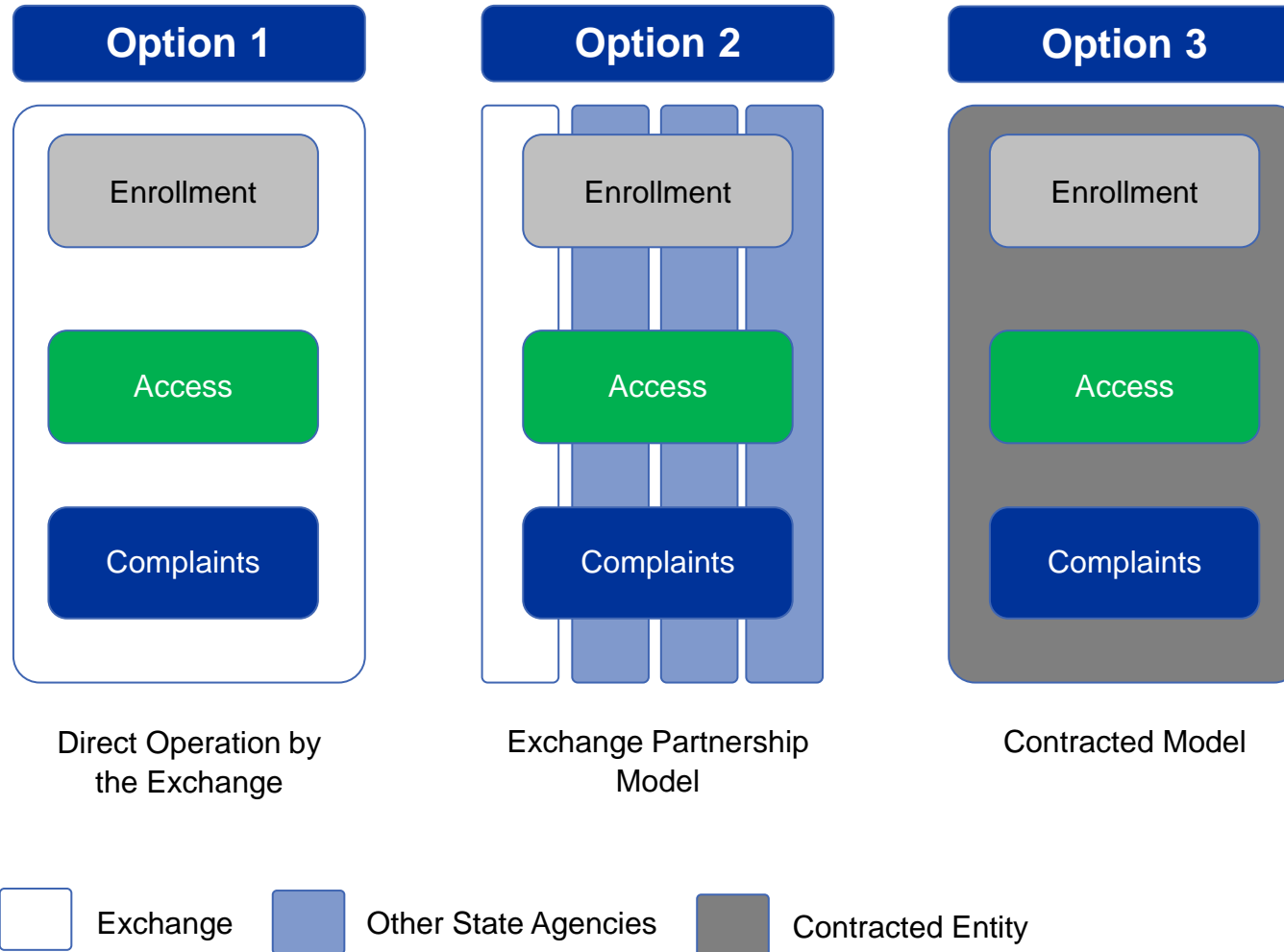
Assessment of Options

Option 1

- *Involves hiring, training, and maintaining a significant staff of consumer support individuals*

    ❑ *Staffing demands will fluctuate to accommodate open enrollment periods which poses challenges in State-based system*

- *Presents a burden on the Exchange in terms of occupying time and resources that could be leveraged to meet higher priority obligations*

Option 2

- *Requires increasing staffing currently in place by a factor greater than 10*

    ❑ *Current staff complete a myriad of tasks in addition to supporting the call center at a few of the State agencies reviewed and would therefore not have the capacity to support Exchange demands*

- *Involves adding additional responsibilities that do not necessarily align with current operations*

- *Presents challenges with scalability to meet demand and potential training conflicts*

Option 3

- *Prepared to handle the daily, weekly, and annual ebb and flow of calls and work that are inherent in call center operations*

- *Infrastructure - software/hardware - in place through 1A procurement*

- *Reduces direct responsibilities of the Exchange to training, monitoring , and contract oversight*

- *Provides the consumer with a seamless, unified consumer support experience*

- *Ability to support all service center functions including printing/fulfillment, walk –ins, translation services, training, etc.*

Recommendation

Based on the initial findings from the Health Management Consultants evaluation, the Exchange recommends contracting with a service center expert for the service center functionality (Option 3)

- The Exchange can procure service center services from an organization that can utilize existing infrastructure procured in 1A plus expand upon that infrastructure to create a state-of-the-art service center with the necessary resources to support the Exchange's needs

- Contracting provides the most flexibility in terms of scalability necessary to meet the fluctuating demand (i.e. open enrollment)

- Eliminates the need for cross-training as resources are dedicated and trained to meet the needs of the Exchange

- Timeliest and most cost effective approach

- Provides a single point of contact for the consumer

Next Steps

Action	Timeframe
Conduct call volume assumptions	May – July 2012
Create Solicitation	August - October 2012
Release Solicitation	November 2012
Award Vendor	2013

MARYLAND HEALTH BENEFIT EXCHANGE

Fraud, Waste and Abuse Plan

May 18, 2012

Fraud, Waste and Abuse (FW&A)

The Affordable Care Act (ACA) has created tough new tools to fight fraud and protect taxpayer dollars including increased sentences for criminals, additional resources, enhanced screening, expanded recovery efforts, etc.

Thus, the Exchange must have in place routine oversight and monitoring of issuer activities and individual and employer activities to prevent, fraud, waste, and abuse

Corporate Compliance and Fraud, Waste and Abuse

Three high-level options for Corporate Compliance and FW&A were explored:

Option 1	Option 2	Option 3
Corporate Compliance	Corporate Compliance	Corporate Compliance
Fraud, Waste & Abuse	Fraud, Waste & Abuse	Fraud, Waste & Abuse
Audits	Audit	Audits
Direct Operation by the Exchange	Exchange Partnership Model	Contracted Model

Legend:
- Exchange
- DHMH – OIG/Exchange Partnership
- Contracted Entity
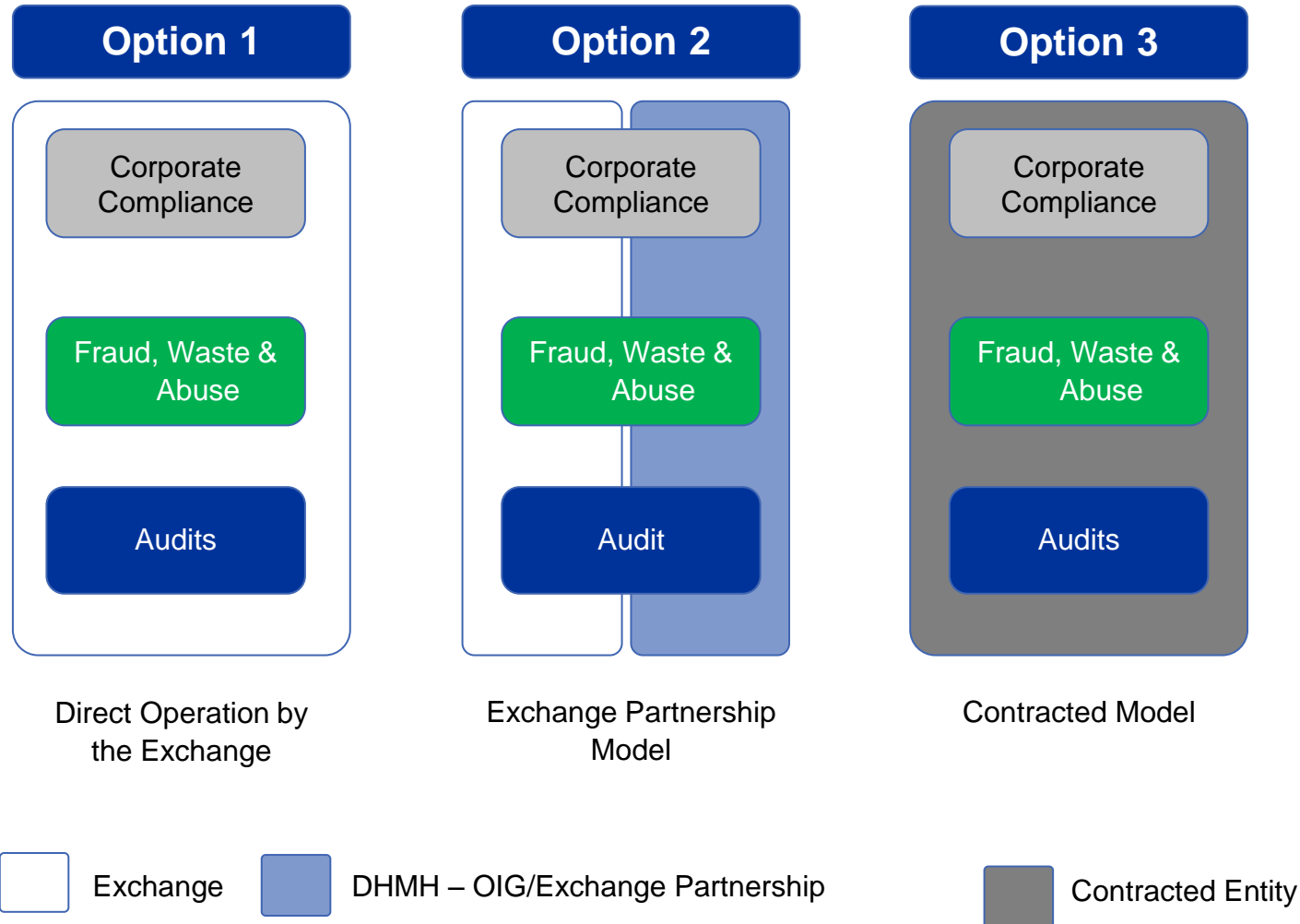
Assessment of Options

Option 1 – Create Internal Exchange Compliance and FW&A Program

- Involves hiring, training, and maintaining a staff

- Developing and procuring the necessary tools to monitor and provide oversight of fraud, waste and abuse activities

- Presents a burden on the Exchange in terms of occupying time and resources that could be leveraged to meet higher priority obligations

Option 2 – Partner with DHMH – Office of Inspector General

- Established program already in place

- Leverage resources and expertise

- DHMH OIG has a proven track record for identifying and investigating allegations of fraud and abuse and recovering monies associated with it.

Option 3 – Contracted Model

- More costly to procure these services

- Outside contractor may not have experience in handling State legislative audits

Recommendation

The Exchange recommends partnering with DHMH's Office of Inspector General to provide its Corporate Compliance, Fraud, Waste and Abuse functions (Option 2).

- The Exchange will request in the Level Two Establishment grant, an internal resource to work as a Liaison with DHMH OIG.

- The OIG's office will support the Exchange by providing the following services:

Corporate Compliance
Program Integrity
Recipient Investigations
Audits (Internal, External, Legislative)
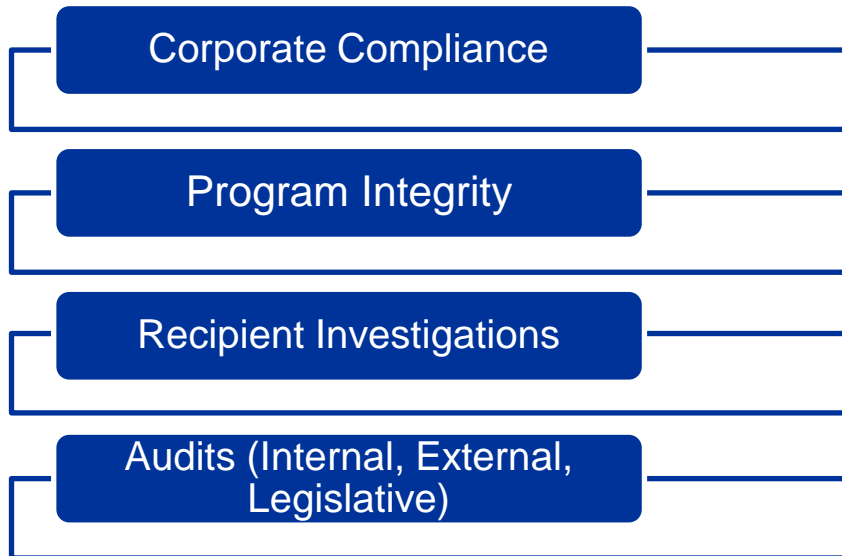
Next Steps

Action
Determine resource needs to support OIG
Develop MOU

MARYLAND HEALTH BENEFIT EXCHANGE

Plan Certification Strategy

Preliminary Criteria, Policy & Process Proposal

May 18, 2012

What is Plan Management?

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                        ┌──────────────────┐
                        │      PLAN        │
                        │   MANAGEMENT     │
                        └──────────────────┘
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Issuer Contracting	Initial Certification	Issuer & Plan Compliance	Renewal and Recertification	Maintain Operational Data	Changes in Plan Availability	Rate Increase Justifications	Decertification	Consumer Plan Presentment
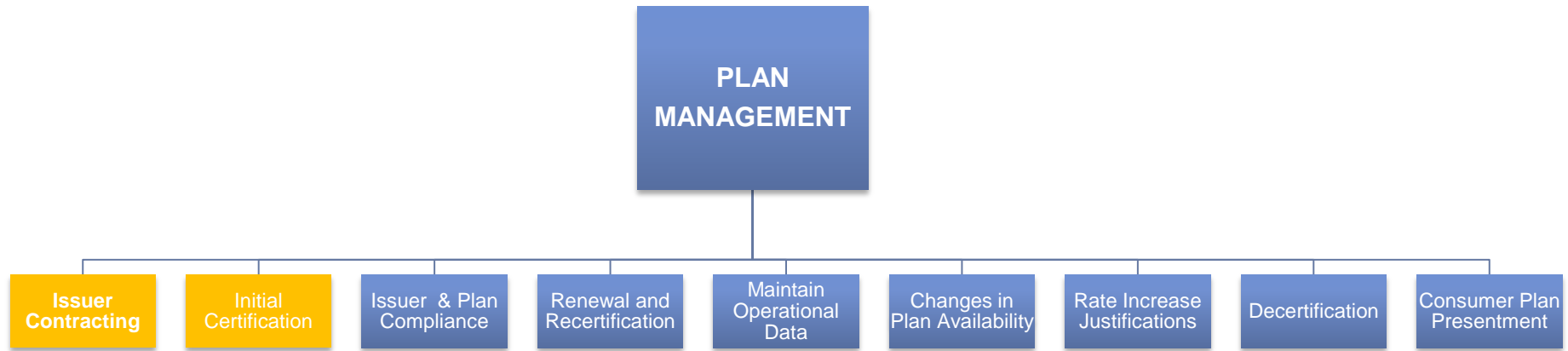
Plan Management encompasses a broad range of functions:

- **Contracting with issuers**

- **Certification of qualified plans**

- Compliance monitoring of plans

- Renewal and recertification of plans

- Maintenance of operational data

- Management of changes in plan availability

- Review of rate increase justifications

- Management of decertification process

- Presentment of qualified plan data to consumers

Proposed Plan Certification Guiding Principles

Plan certification is a critical component of Plan Management. The Exchange will use the following guiding principles to establish its certification approach for qualified plans:

- **Promote affordability** for the consumer and small employer

- **Ensure access to quality care** for consumers presenting with a range of health statuses and conditions

- **Facilitate informed choice of health plans and providers** by consumers and small employers

- **Foster health equity**

Given these principles, a proposed plan certification policy has been developed.

Feedback from stakeholders from around Maryland will be used to help finalize the policy.

Stakeholder Process Review

Advisory Committee Feedback from EIAC
and Plan Management Committees

Public Comment

	Pre-work (including Advisory Commitees' input and development of plan)				Public Comment Period		Board Approval and Implemenation		
Subject Area	Obtain Exchange Implementation Advisory Committee (EIAC) Input	Obtain other Subject Matter Experts' (SME) Input	Obtain Plan Management Advisory Committee Feedback on EIAC and SME Recommendations	Develop Preliminary Certification Proposal	Public Comment Period	Review/Analyze Comments and Develop Final Certification Plan	Present Final Certification Plan to Board	Develop a Plan Certification Manual for Carriers	Communicate Plan Certification Requirements to Carriers
Qualified Plans Certification (QHP/QDP/QVP)	4/1/2012-5/30/2012	4/1/2012-5/30/2012	5/30/2012-7/13/2012	7/13/2012-7/27/2012	7/27/2012-8/17/2012	8/17/2012-9/4/2012	9/11/2012	9/11/2012-9/21/2012	9/24/2012-9/28/2012

Proposed Plan Certification Process

Step 1 Contracting with the Exchange	Step 2 MIA Approval	Step 3 Exchange Final Approval
(Issuer Level)	(Plan level)	(Plan level)
Service Area Requirements	**SERFF** →	**HIX**
Marketing Standards	Licensure	Accreditation
Transparency Standards	Solvency	Network Adequacy
Continuity of Care Requirements	Benefits, Rates & Forms	Essential Community Providers
Quality Data Requirements	Essential Health Benefits	Transparency Data
Tracking of RELCC Data	Limitations on Cost Sharing	
Reporting Requirements	Actuarial Value/Metal Levels	
	Discriminatory Benefit Design	

Plan Quality Proposal

Quality Data Sharing with MHCC

- Maryland has a 15-year history of monitoring quality and performance of commercial health plans through processes established by the Maryland Health Care Commission (MHCC).

- MHCC's process leverages both the Consumer Assessment of Health Providers and Systems (CAHPS) from the Agency for Healthcare Research and Quality (AHRQ) and Healthcare Effectiveness Data and Information Set (HEDIS) from the NCQA.

Proposal:

- Collaborate with MHCC to collect quality data for commercial health, dental and vision plans.
  - Develop a process to collect and report upon quality data for dental and vision plans using a modified CAHPS survey tailored to these types of plans.

- Use commercial data initially, until Exchange-specific data is available.

Disparity Measurement & Reduction Proposal

Race, Ethnicity, Language, Cultural Competence (RELCC) Data Tracking

- The Exchange recognizes that there are significant disparities in health care and health outcomes among racial and ethnic groups in Maryland.

Proposal:

- Require issuers to track and report RELCC data to the MHCC.

- Work with MHCC to capture RELCC information for the Exchange population so that healthcare disparities can be analyzed and addressed in future years.

- Collaborate with the DHMH Office of Minority Health and Health Disparities & the Maryland Health Disparities Collaborative to identify how their research on health care disparity measures and variations in quality and outcomes for health plans can be incorporated in the certification policy.

Next Steps

- Review with advisory committees to obtain feedback

- Revise as needed

- Review with board

MARYLAND HEALTH BENEFIT EXCHANGE

Information Technology
Gap Analysis

May 14, 2012

Purpose of IT Gap Analysis for Level 2 Establishment Grant Application

- Describes Maryland's "state of readiness" to implement Exchange IT systems for required functions of the Exchange

- Addresses gaps between "As-Is" technical environment and "To-Be" technical architecture

- Demonstrates how the target environment maximizes use of standards for security, privacy, data exchanges, usability, and accessibility

Maryland's Current Eligibility Determination and Enrollment Landscape

'As-Is' Context Diagram
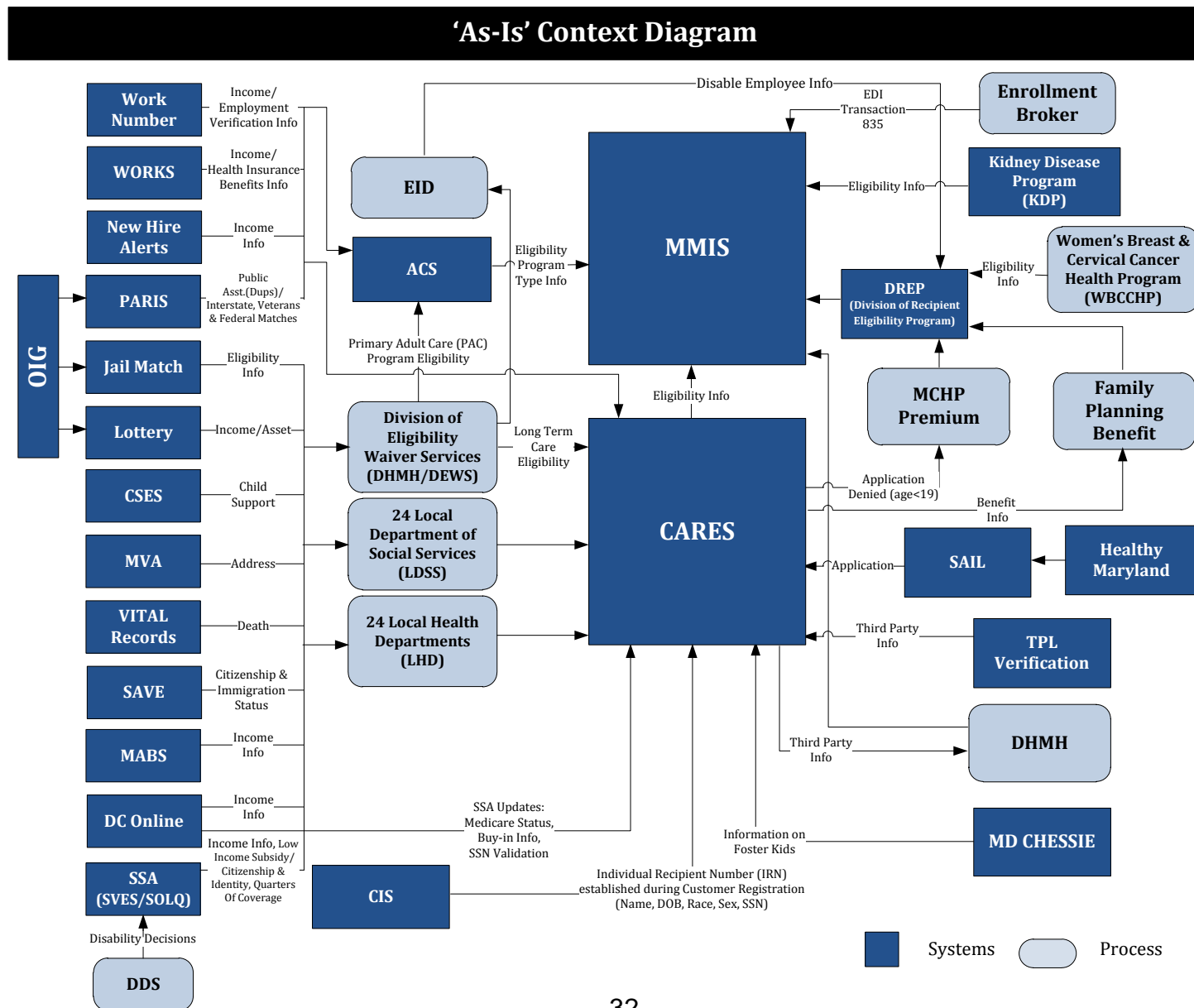
Maryland's Target Technical Architecture for Phase 1A
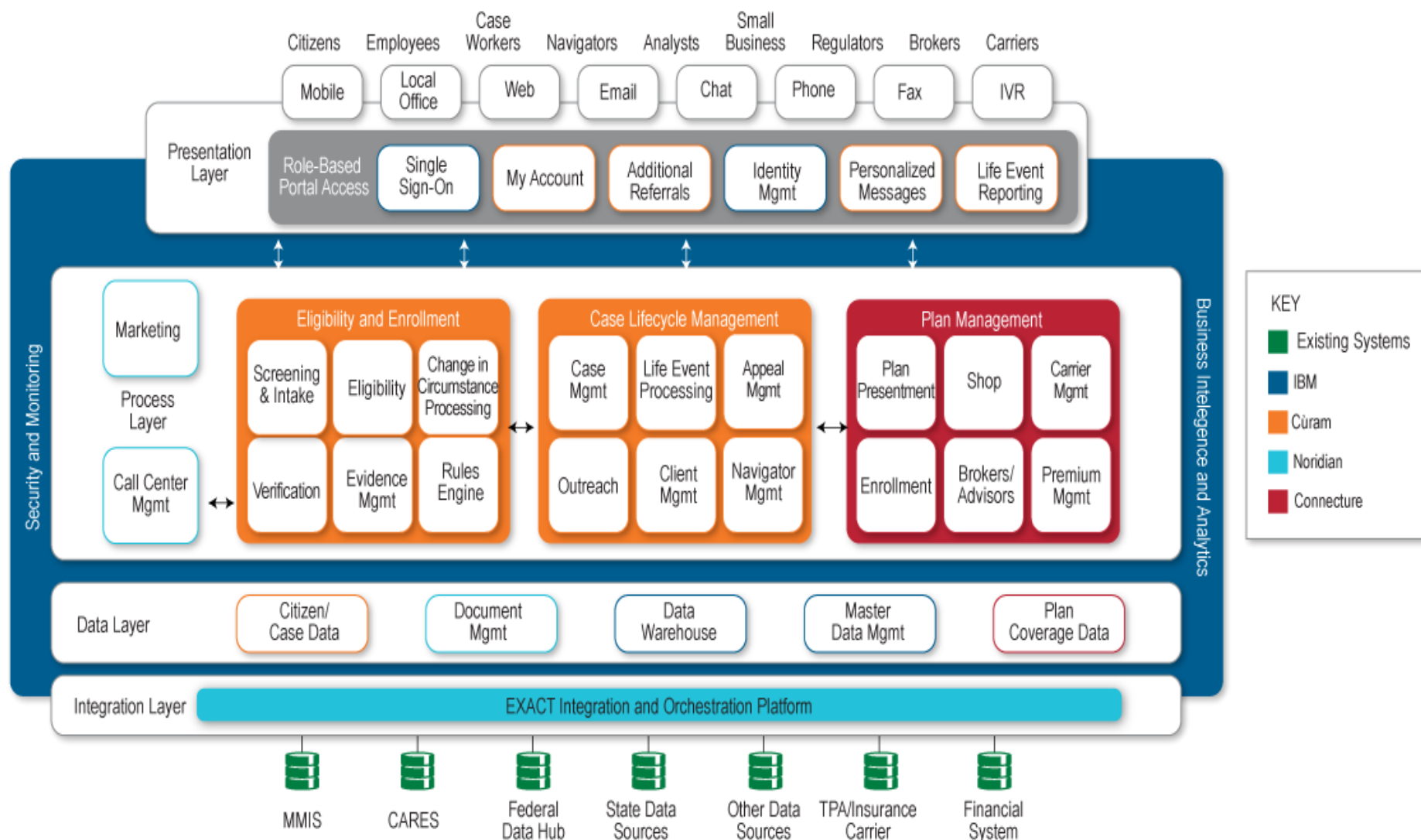
The Exchange IT and Systems Landscape

- **Core HIX Functional Components:** Technology to support the required business functions of the Exchange (e.g. Eligibility Determinations, Enrollment, etc.)

- **Core HIX Non-Functional Components:** Common technical components that provide the underlying standards-based framework for all functional components (security, role-based access control, messaging, document management , master data management, etc.)

- **Systems Interfaces and Data Exchanges:** Technology to support integration with partner systems including federal and state systems, carriers, MCO's, and TPAs.

- **Supporting IT Services:** Processes and techniques to ensure the proper design and implementation of technology including project management, quality assurance, data migration, etc.

- **Internal Exchange Back-Office IT:** Basic IT technology and services required to support the office productivity and administrative needs of an organization

Core HIX Functional Components

- **Existing Technical Capabilities:** None

- **Procured under Phase 1A & Level 1 Establishment Grant:**
  - Qualified Health Plan (QHP) management system (Connecture)
  - "No Wrong Door" Eligibility determination system (Curam)
  - Plan Presentment and Comparison system – i.e. online shopping experience (Connecture)
  - Enrollment system (Curam & Connecture)
  - Case Management system (Curam)
  - Call Center / Interactive Voice Response (IVR) system (CIC - Partial)
  - Document Management and Online Help (On Base)
  - Required Reporting, Notices, and Constituent Communications
  - Premium Billing and Collections (Noridian – Partial)

- **Funding Sought under Level 2 Establishment Grant:**
  - SHOP QHP management system
  - SHOP Online Marketplace (plan presentment and enrollment) system
  - SHOP Premium Billing and Collections system
  - SHOP Financial and Operations Oversight system
  - SHOP Call Center system
  - SHOP Interfaces and connections to certified TPAs
  - Banking and Cash Management Services
  - Reinsurance System

Core HIX Non-Functional Components

- **Existing Technical Capabilities:** None

- **Procured under Phase 1A & Level 1 Establishment Grant:**
  - Enterprise Service Bus (Exact)
  - Master Data Model (Exact)
  - External Rules Engine (Exact, Curam, and Connecture)
  - Constituent Account Management
  - Security and Role-Based Access Control (RBAC)
  - DDI Hosting Facility inclusive of hardware and software licenses (Noridian)

- **Funding Sought under Level 2 Establishment Grant for:**
  - Extract, Transformation, Load (ETL) system
  - Production IT Hosting facility / data center
  - Disaster Recovery and Business Continuity establishment
  - Kiosks and publically available customer self-service systems

Systems Interfaces and Data Exchanges

- **Existing Technical Capabilities:** HIX system will integrate with existing partner systems and external data sources that will continue to remain in use

- **Interoperability Procured under Phase 1A & Level 1 Establishment Grant:**
  - Federal Data Hub (for citizenship and income verification)
  - Insurance Carriers (QHP exchanges, enrollment, other operations)
  - Managed Care Organizations (Plan exchanges, enrollment, other operations)
  - CARES (Legacy state-wide eligibility system) - Partial
  - MMIS (Core Medicaid Management Information System) - Partial

- **Funding Sought under Level 2 Establishment Grant for Interoperability with the following:**
  - SERFF (System used by MIA for carrier QHP certification)
  - FMIS (State-wide accounting system)
  - Navigator Entities
  - Local Health and Social Service Departments
  - Other State Eligibility Data Sources (e.g. Vital Records, MVA, MD CHESSIE, SAIL, PARIS, WORKs, etc.)
  - Third Party Administrators (multiple systems that will support SHOP functions)

Supporting IT Services

- **Existing Technical Capabilities:** None

- **Procured under Phase 1A & Level 1 Establishment / Early Innovator Grant:**
  - Program Management Office (PMO)
  - Reusability and Shared Services - Partial
  - Transition to Production Environment

- **Funding Sought under Level 2 Establishment Grant for:**
  - Independent Validation and Verification (IV&V)
  - Data Migration
  - User Training
  - Additional Navigator Functionality (e.g. certification and training program)
  - Consumer Outreach
  - Organizational Change Management (revised policies and operating procedures)

Internal Back-Office IT Services

- **Existing Technical Capabilities:** Some depending on how closely the Exchange stays aligned organizationally with other State agencies

- **Procured under Phase 1A & Level 1 Establishment Grant:**
  - Capacity to pay for services provided by State Agencies

- **Funding Sought under Level 2 Establishment Grant for:**
  - Telecommunications
  - Internet Connectivity and Network Infrastructure
  - Secure Network and File Management Services
  - Back-up and recovery
  - Asset management
  - IT Support Desk
  - Back-Office Administrative Systems (e.g. HR, Accounting, Payroll, etc.)
  - External Web Presence and Content Management
  - eMail and Mobile Services
  - Desktop Productivity (e.g. Desktops, Laptops, MS Office Software)

Next Steps

- Make business decisions (or assumptions) impacting scope and nature of IT investments (e.g. individual premium collection & billing)

- Finalize list of contracts and IT-related expenditures through 2014

- Estimate budget for contracts and IT-related expenditures not covered under the Level 1 Establishment Grant

- Complete narrative for Level 2 Establishment Grant

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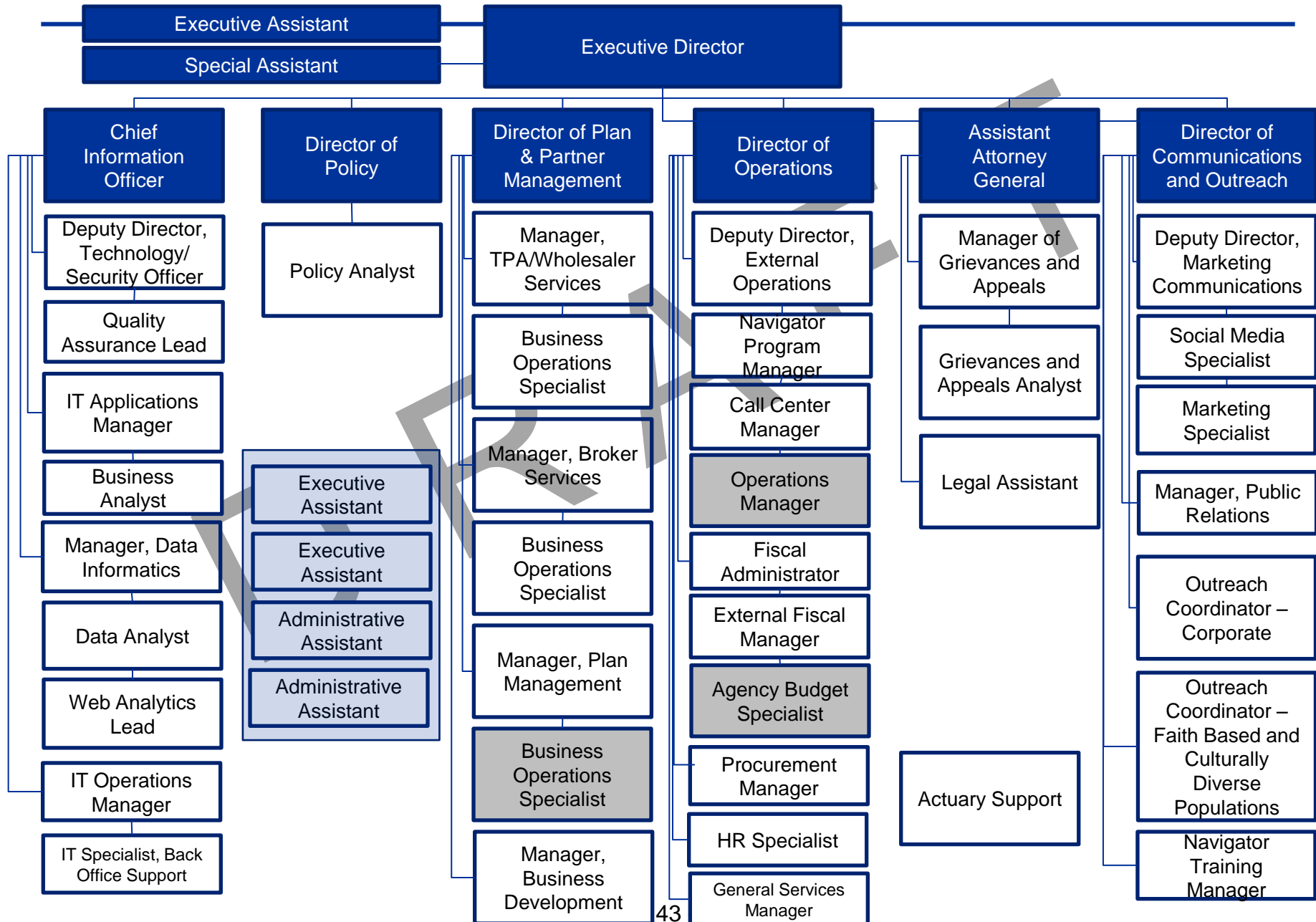
Draft Proposed Organization Chart
For Discussion

May 18, 2012

Overarching Principles

- Lean organization

- Focused to ensure compliance with ACA requirements

- Focused on 2014 with identified areas for expansion when volume increases

- Base-lined against other org charts across the country

- Working with DHMH HR to streamline position titles, requirements, etc.

Proposed Organizational Chart for 2014 and Beyond

Executive Assistant

Special Assistant

Executive Director

Chief Information Officer
- Deputy Director, Technology/Security Officer
- Quality Assurance Lead
- IT Applications Manager
- Business Analyst
- Manager, Data Informatics
- Data Analyst
- Web Analytics Lead
- IT Operations Manager
- IT Specialist, Back Office Support

Director of Policy
- Policy Analyst

- Executive Assistant
- Executive Assistant
- Administrative Assistant
- Administrative Assistant

Director of Plan & Partner Management
- Manager, TPA/Wholesaler Services
- Business Operations Specialist
- Manager, Broker Services
- Business Operations Specialist
- Manager, Plan Management
- Business Operations Specialist
- Manager, Business Development

Director of Operations
- Deputy Director, External Operations
- Navigator Program Manager
- Call Center Manager
- Operations Manager
- Fiscal Administrator
- External Fiscal Manager
- Agency Budget Specialist
- Procurement Manager
- HR Specialist
- General Services Manager

Assistant Attorney General
- Manager of Grievances and Appeals
- Grievances and Appeals Analyst
- Legal Assistant

- Actuary Support

Director of Communications and Outreach
- Deputy Director, Marketing Communications
- Social Media Specialist
- Marketing Specialist
- Manager, Public Relations
- Outreach Coordinator – Corporate
- Outreach Coordinator – Faith Based and Culturally Diverse Populations
- Navigator Training Manager

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Next Steps

- Classify and align positions within state system

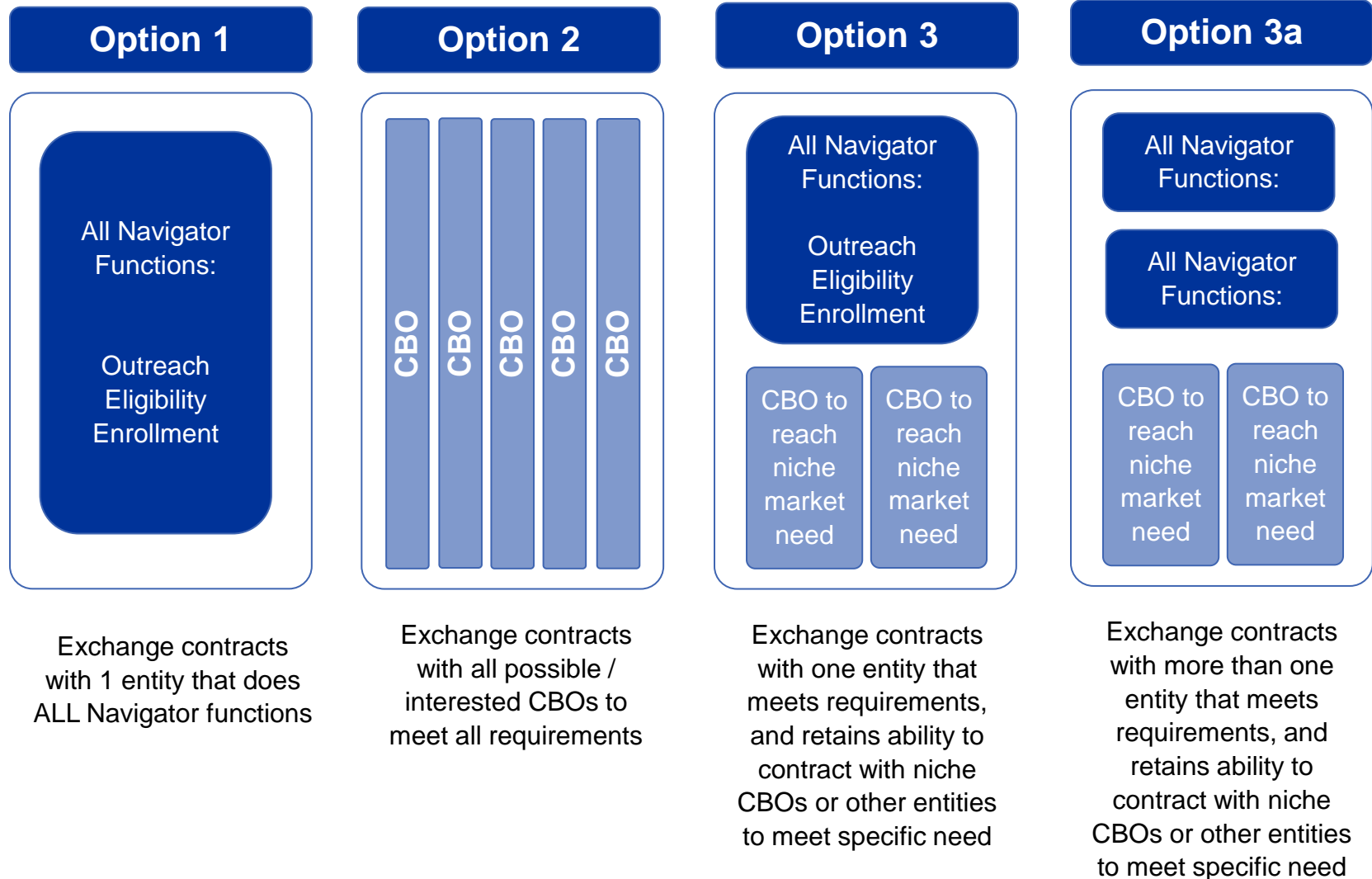- Outline budget needs based on classification

- Insert into Level 2 grant

MARYLAND HEALTH BENEFIT EXCHANGE
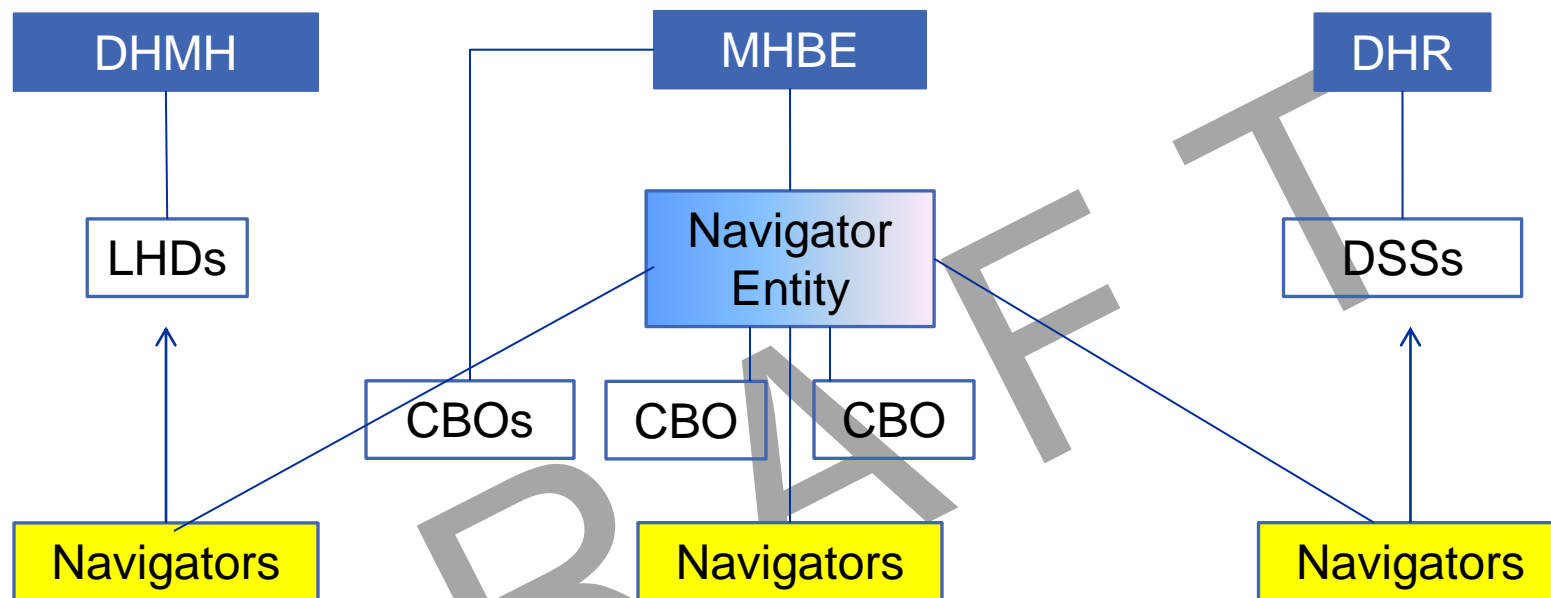
Draft Navigator Contracting Model
For Discussion

May 18, 2012

Navigator Entity Options

There were several options defined during the committee process in 2011:

Option 1	Option 2	Option 3	Option 3a

Option 1

All Navigator Functions:

Outreach
Eligibility
Enrollment

Option 2

CBO CBO CBO CBO CBO

Option 3

All Navigator Functions:

Outreach
Eligibility
Enrollment

CBO to reach niche market need

CBO to reach niche market need

Option 3a

All Navigator Functions:

All Navigator Functions:

CBO to reach niche market need

CBO to reach niche market need

Exchange contracts with 1 entity that does ALL Navigator functions

Exchange contracts with all possible / interested CBOs to meet all requirements

Exchange contracts with one entity that meets requirements, and retains ability to contract with niche CBOs or other entities to meet specific need

Exchange contracts with more than one entity that meets requirements, and retains ability to contract with niche CBOs or other entities to meet specific need

Proposed Individual Navigator Contracting Strategy

Navigator Entity:
- Can subcontract to meet all requirements
- Can choose to come together as conglomerate
- Will need to have navigators available for each LHD and DSS office
- Must prove their relationships with the communities in which they serve

Exchange:
- Will contract with Navigator Entity
- Maintains the ability to contract with individual CBOs a needed
- Has no direct payment relationship with LHDs or DSSs unless they become Navigator Entity

Next Steps

- Review with Navigator Advisory Committee

- Discuss pros/cons of multiple Navigator Entities

- Come back with recommendation to board for final plan

Upcoming Meetings

- Budget

- Appeals and Grievances

- Marketing Plan

- Individual Billing and Payment